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Social Determinants of Health: Data Advancement for Utah

Digital Health Services Commission January 9, 2020

Definition

Social Determinants of Health: nonmedical factors influencing health, including health-related knowledge, attitudes, beliefs, or behaviors.

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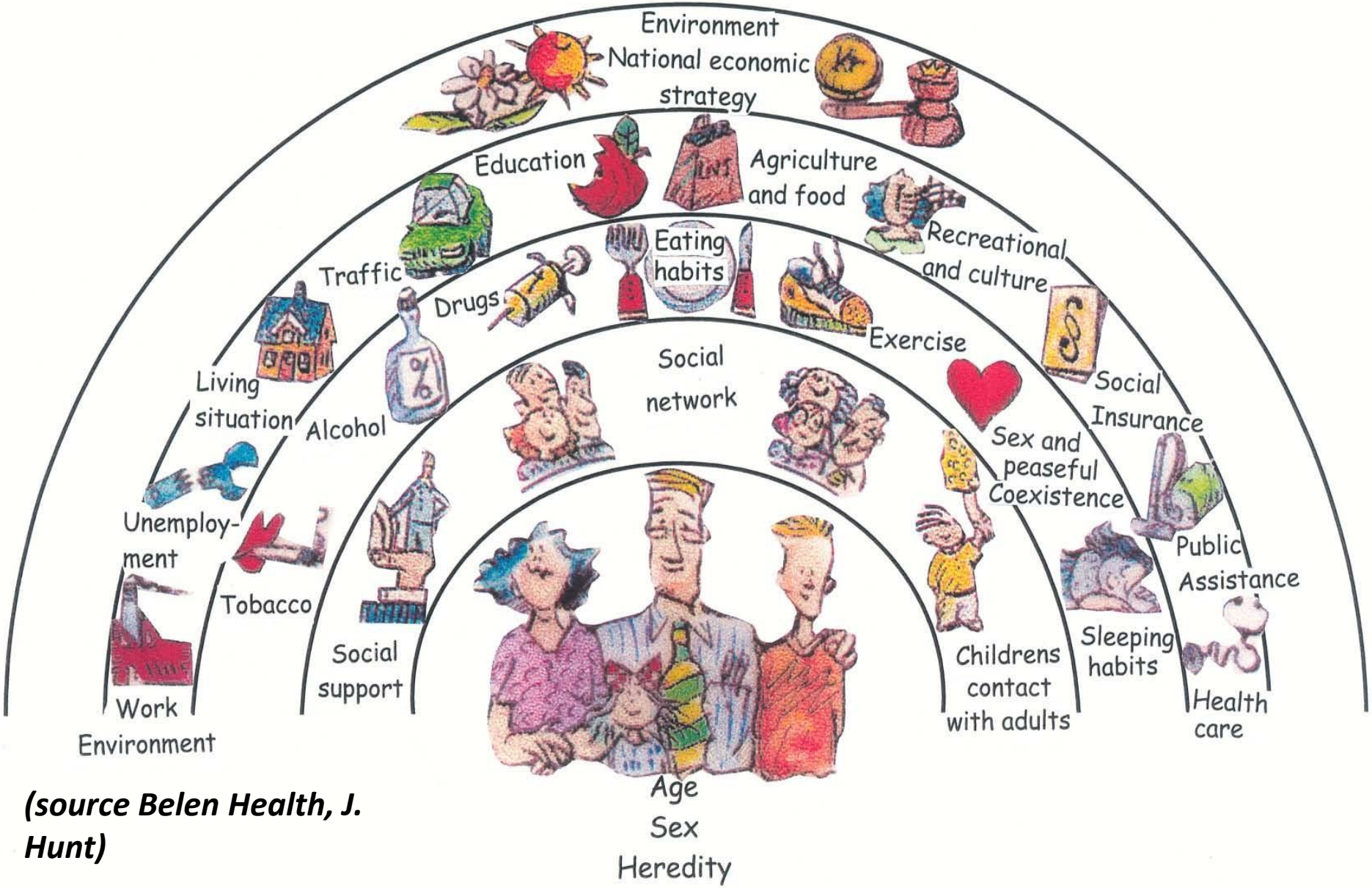
Determinants of health



(source Belen Health, J. Hunt)

Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health, 2019

- Advances in technology have the potential to facilitate integration of the health care and social care sector
- Local efforts to share health care and social care information are not supported by a national strategy or coupled with resources
- Interoperability and data sharing between health care and social care are hampered by the lack of infrastructure, data standards, and modern technology architecture shared between and among organizations.

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Five Goals for Effective Integration and Select Recommendations from the National Academies of Sciences, Engineering, and Medicine, 2019

1. Design health care delivery to integrate social care into health care.
2. Build a workforce to integrate social care into health care delivery.
3. Develop a digital infrastructure that is interoperable between health care and social care organizations.
4. Finance the integration of health care and social care.
5. Fund, conduct, and translate research and evaluation on the effectiveness and implementation of social care practices in health care settings.

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http://nationalacademies.org/hmd/~/media/Files/Report%20Files/2019/SocialCare/report-release-slides.pdf

State HIT Plan Goal Alignment

GOAL 2: STRENGTHEN HEALTH CARE DELIVERY TRANSFORMATION

GOAL 3: ENHANCE UTAH'S INTEROPERABLE HEALTH IT INFRASTRUCTURE

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Objective

- Update on current projects addressing the social determinants of health
- Assess opportunities to remove barriers to success
- Identify gaps that our multi-stakeholder Commission might work to bridge

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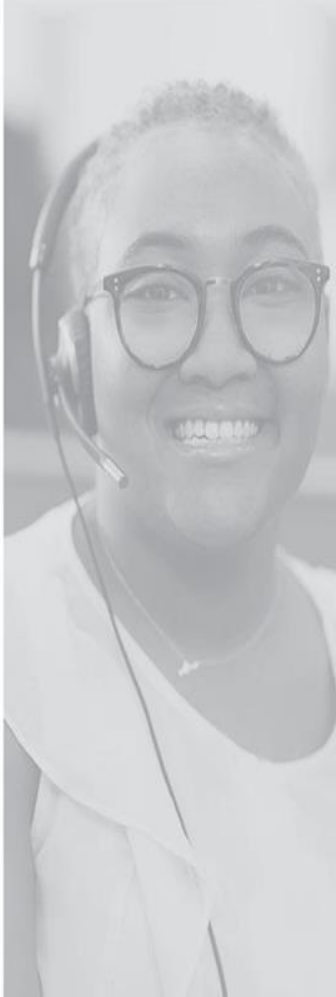
Caitlin Schneider, MPH
Partnerships Director
United Way of Salt Lake

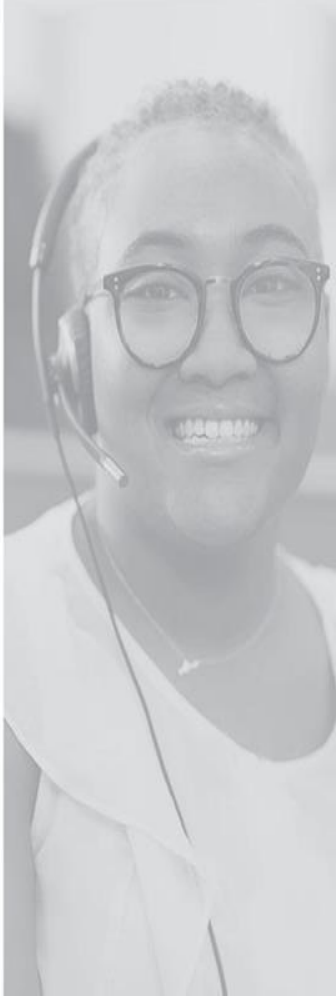
United Way's 211



Vision

A 211 system that helps ensure every person in the state has their basics needs met, including shelter, clothing, food, access to appropriate healthcare, and personal safety.

2·1·1
Get Help. Give Help.
United Ways of Utah



211 Helpline

Free

Confidential

Available 24/7

Local resources in one location

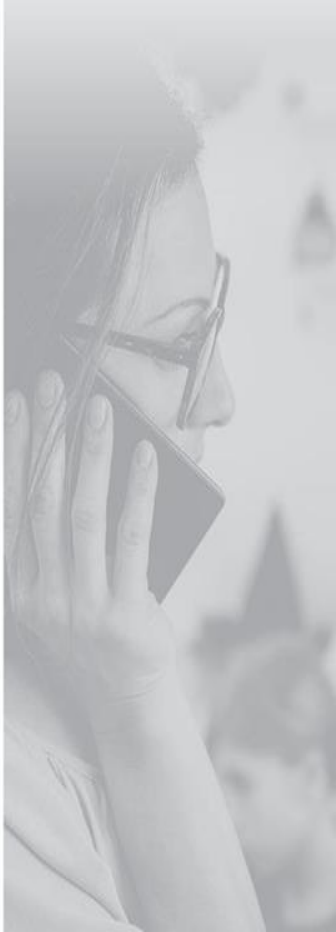
Services in over 200 languages

Follow-up with Clients

Included in the 211 Database

2,904
Total Providers

9,731
Services



Social Determinants of Health

- Convene a group of about 50 health and social service providers interested in connecting individuals to community resources to reduce healthcare cost and hospital readmissions, as well as improve the overall quality of life for the individuals served.
- Working to create a closed loop referral system for the state of Utah, using 211 as the central database.

Social Determinants of Health Data

- Each provider record is updated at least annually
- Extensive data on demographics, needs and referrals for those that connect with 211 collected within the 211 database
- Create client records for individuals that want to receive a follow-up
- Database is HIPAA compliant and client information is kept confidential
- Data is available in aggregate as requested and updated periodically on the 211 website

Social Needs Screening and 211 Referral in the University of Utah Health Emergency Department

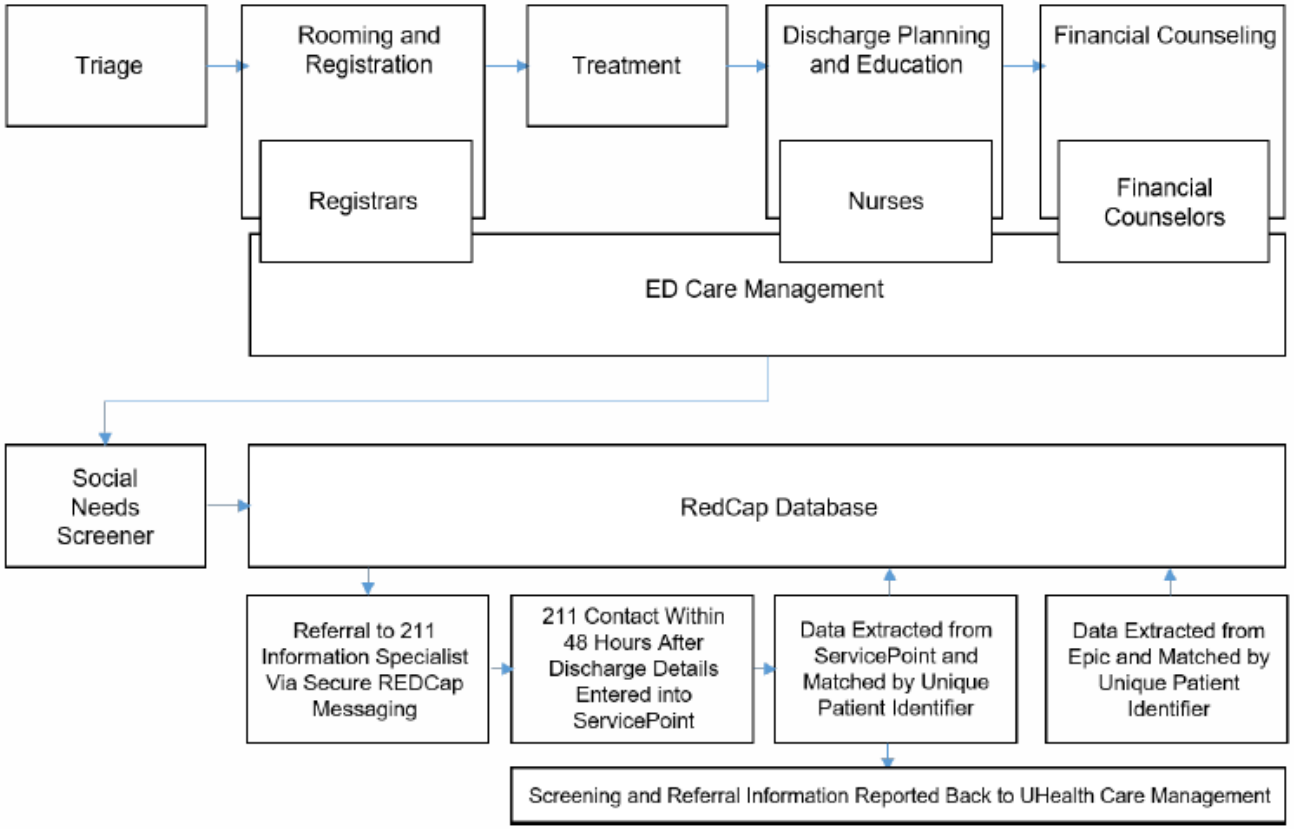
Andrea Wallace PhD RN FAAN
Associate Professor
University of Utah College of Nursing
Presentation made to Utah Digital Health Services Commission
January 9, 2020

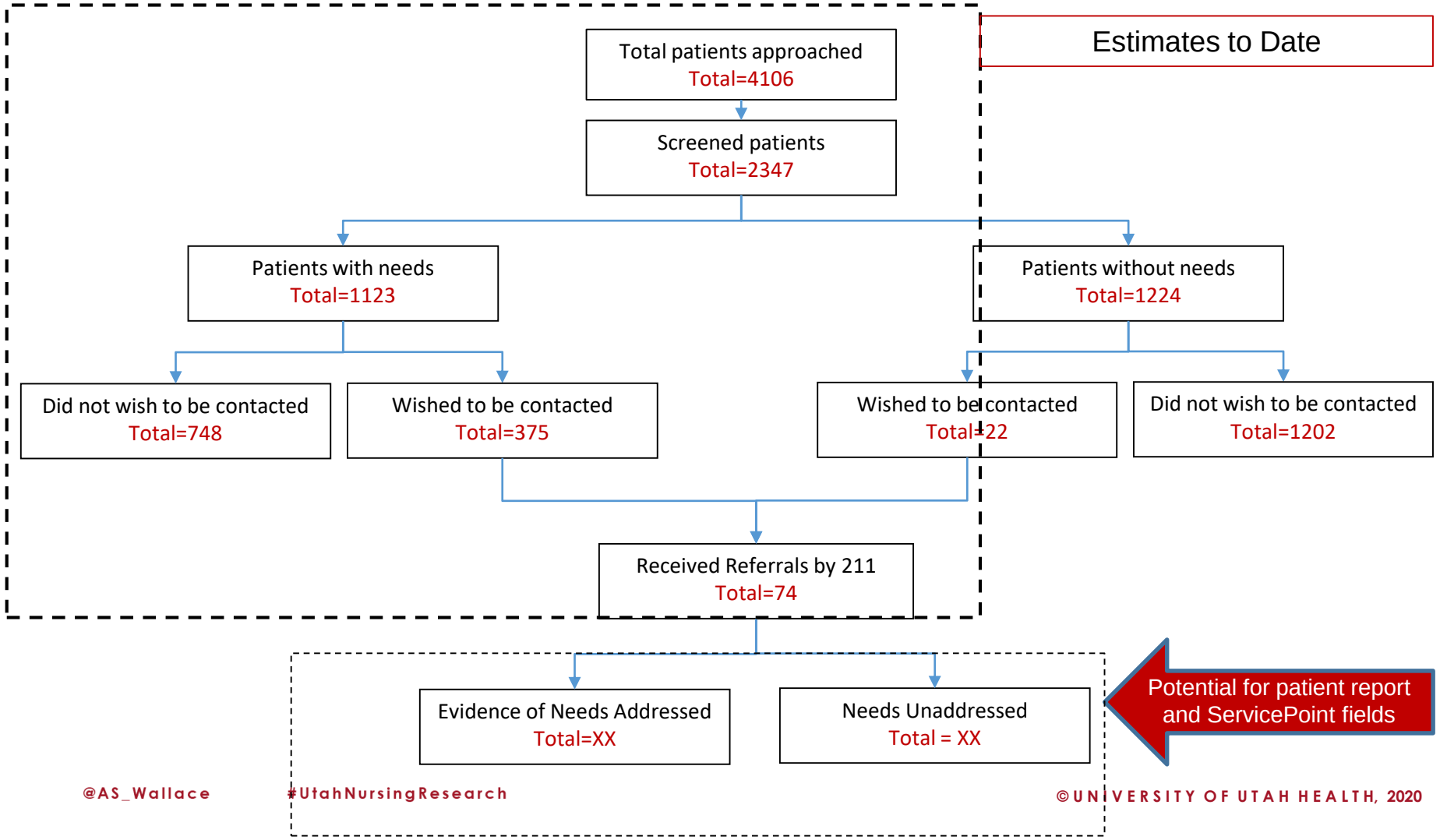
Funding Provided by Agency for Healthcare Research and Quality
R21 HS026505

Screening, Referral, and Data Sharing

- ED patients screened for social needs in REDCap on touchscreens: 10-items, low literacy, dichotomous (yes/no) answers
- United Way 2-1-1 information specialist, with limited REDCap access (names, phone/email, zip code), contacts patients wishing follow-up within 48 hours
- Data compiled: Screener, 2-1-1 ServicePoint encounter, UHealth Enterprise Data Warehouse

Approach: Touchpads, REDCap, ServicePoint and Data Warehouse




Estimates to Date
Total patients approached
Total=4106
Screened patients
Total=2347
Patients with needs
Total=1123
Patients without needs
Total=1224
Did not wish to be contacted
Total=748
Wished to be contacted
Total=375
Wished to be contacted
Total=22
Did not wish to be contacted
Total=1202
Received Referrals by 211
Total=74
Evidence of Needs Addressed
Total=XX
Needs Unaddressed
Total = XX
Potential for patient report and ServicePoint fields
@AS_Wallace
#UtahNursingResearch
©UNIVERSITY OF UTAH HEALTH, 2020

Summary

- Links between screening, referrals, and health outcomes can be achieved using existing technology and available workflows
- Next Steps in universal social needs screening and data exchange
  - Thoughtfully address bias, patient preferences and receptivity, coaching to facilitate screening and follow-up
  - Refine and optimize ServicePoint data fields

Intermountain® Healthcare

Collecting, Sharing, and Using SDOH Data

Utah Digital Health Services Commission
January 9, 2020

Gene Smith
Director, Community Health &
Alliance for the Determinants of Health

Helping people live the healthiest lives possible.®

Intermountain Impact

- 24*Hospitals *One Virtual Hospital
- 160 Physician Clinics
- 875,000 SelectHealth Members
- $2.7B Annual Supply Chain Spend
- 38,000 Employees
- $225M Charity Care

ALLIANCE FOR THE DETERMINANTS OF HEALTH

A collaborative approach to addressing and achieving health equity in our communities

Intermountain® Healthcare

Alliance for the Determinants of Health

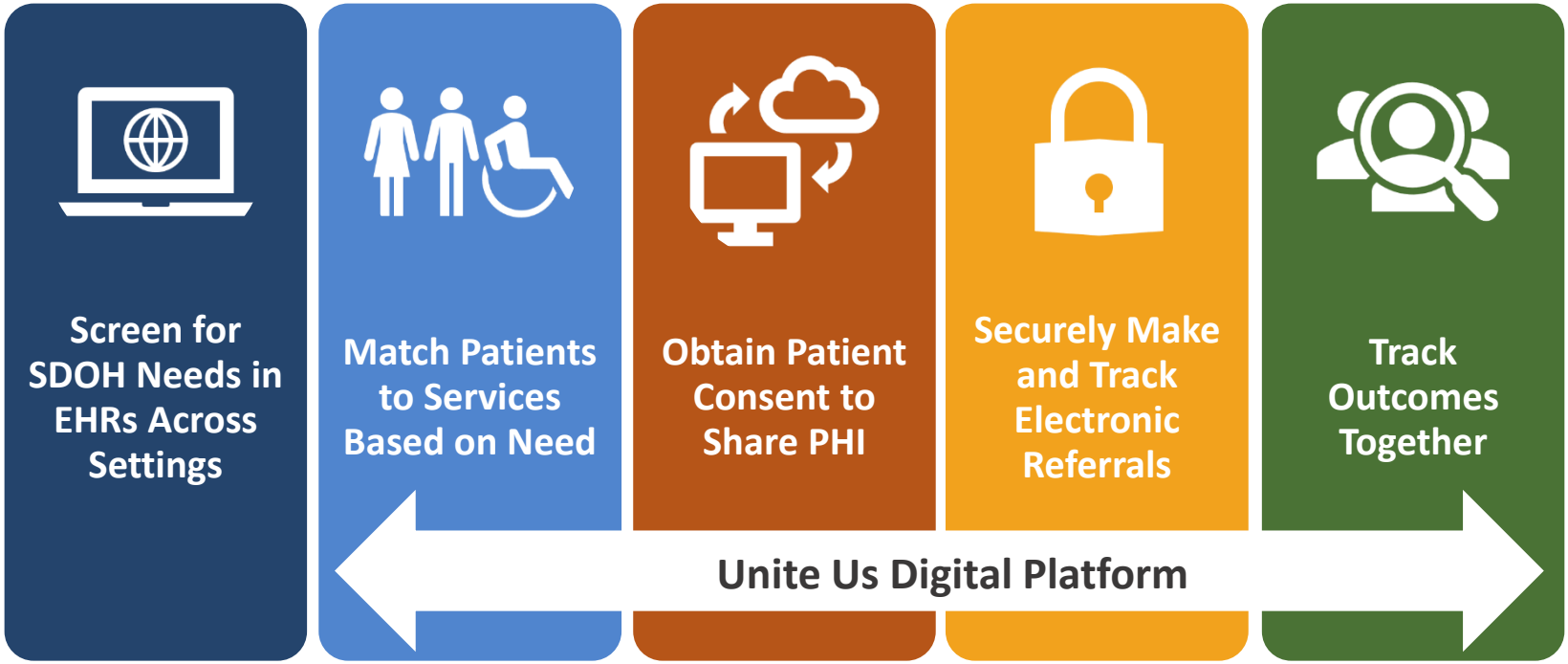
Three-Year, $12M Demonstration:

1. **Increase access** to SDOH-focused community partners
2. **Provide community health workers** in the field with funding for short term crisis needs
3. **Align social services and care delivery** through technology and data sharing solutions
4. **Remove silos** among delivery systems, public health and community partners through innovative partnerships

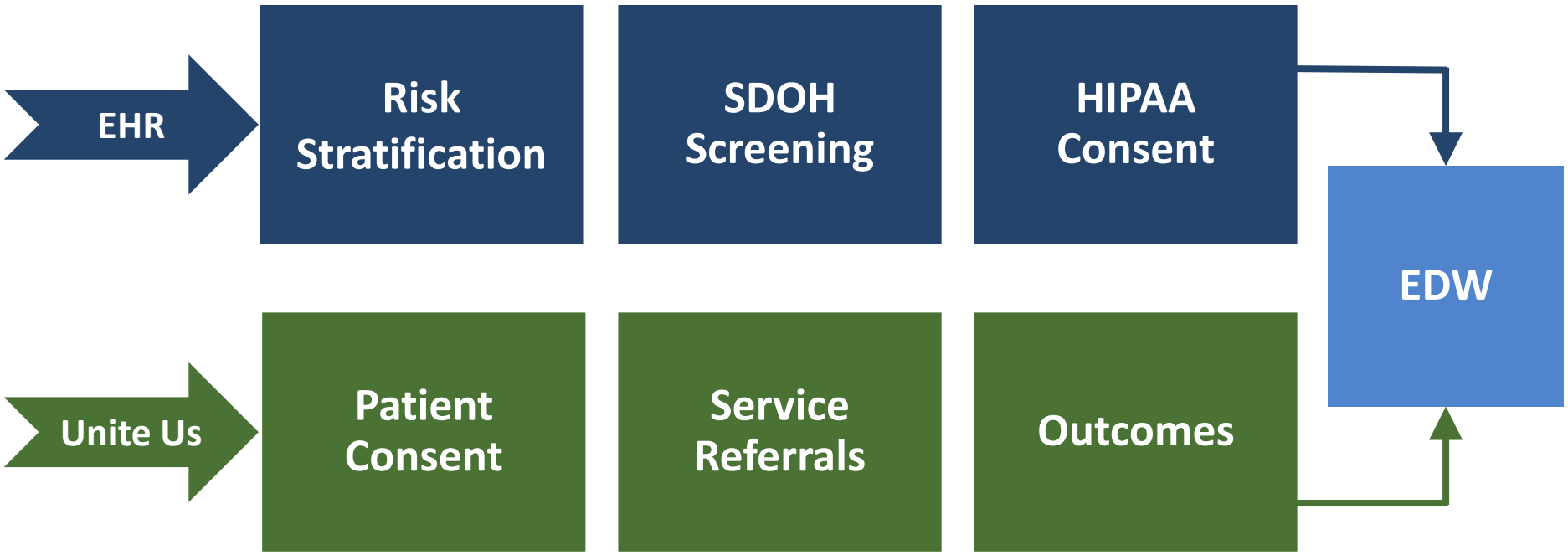
KPI: Lower medical expense by reducing avoidable ED visits

ALLIANCE FOR THE DETERMINANTS OF HEALTH

Connect Us
Building Healthier Communities



Collecting SDOH Data



Sharing and Using SDOH Data

- Shared with clinical partners via dashboards and EHR
- Used to identify and prioritize patients to screen

- Shared across ED and clinic settings via EHR
- Used to trigger alerts and advisories to initiate screening workflows

- Shared via EHR and digital platform
- Used to match patients with services and generate referrals

- Shared via digital platform and exported to EDW
- Identified data used for referral management and care coordination
- De-identified data used for outcomes reporting and program evaluation

Thank You

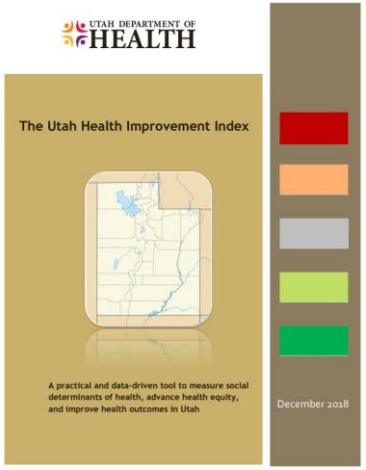
Social Determinants of Health Efforts at the Utah Department of Health

Anna Dillingham, MPH
Director, Office of Public Health Assessment
Utah Department of Health

Health Improvement Index

The HII is a weighted composite measure of social determinants of health (SDoH) indicators from Utah's Behavioral Risk Factor Surveillance System by geographic area. Those indicators are:

1. Population aged ≥25 years with <9 years of education, %
2. Population aged ≥25 years with at least a high school diploma, %
3. Median family income, $
4. Income disparity
5. Owner-occupied housing units, % (home ownership rate)
6. Civilian labor force population aged ≥16 years unemployed, % (unemployment rate)
7. Families below poverty level, %
8. Population below 150% of the poverty threshold, %
9. Single-parent households with children aged <18 years, %



https://health.utah.gov/disparities/data/ohd/UtahHII.pdf

https://health.utah.gov/disparities/data/ohd/HealthDisparitiesbyUtahStateLegislativeDistrict2019.pdf

The Higher the HII, the More Improvements the Area Needs

- Very high HII >120
- High HII >105 and <= 120
- Average HII >94 and <=105
- Low HII >80 and <=94
- Very low HII <80

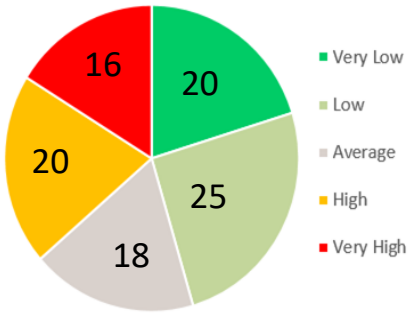


Table: Salt Lake County Summary

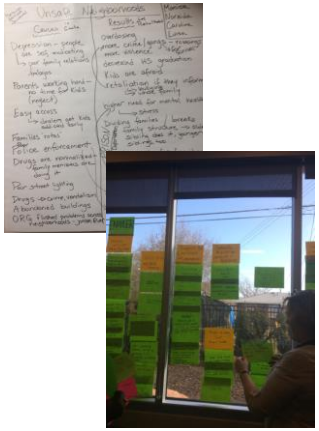
Geography	Health Improvement Index (HII) Score	Population (2018)	% Racial/ Ethnic Minority (2014–2018)	Infant Mortality Rate per 1,000 (2014–2018)	Life Expectancy at Birth (2014–2018)	% Adults Reporting Fair/ Pooer Health (2016–2018)
State of Utah	N/A	3,161,105		5.3	79.8	13.7%
Salt Lake County LHD	N/A	1,152,633		5.7	79.5	14.7%
SMALL AREAS						
17 Salt Lake City (Rose Park)	130.7	36,796	63.6%	6.3	77.3	18.9%
18 Salt Lake City (Avenues)	87.2	24,309	16.4%	3.6*	85.8	6.0%
19.1 Salt lake City (Foothill/East Bench)	83.5	21,380	16.2%	5.2*	85.2	7.6%
20 Magna	119.0	28,760	38.9%	7.7	75.5	16.8%
21.1 Salt Lake City (Glendale) V2	150.7	24,957	68.4%	9.2	75.5	23.3%
22.1 West Valley (Center)	128.7	52,741	52.0%	6.3	78.1	19.7%
22.2 West Valley (West) V2	95.8	32,032	49.0%	5.1	76.9	17.0%
23.1 West Valley (East) V2	142.8	53,675	54.3%	5.6	77.4	26.0%
24.1 Salt Lake City (Downtown) V2	117.9	38,650	28.4%	8.9	75.3	18.3%
24.2 Salt Lake City (Southeast Liberty)	90.0	22,756	14.6%	3.7*	81.0	7.2%
25 South Salt Lake	137.6	27,881	42.6%	7.8	73.7	24.6%
26.1 Salt Lake City (Sugar House)	101.6	34,414	19.1%	4.1*	79.2	13.9%
26.2 Millcreek (South)	79.1	21,893	14.0%	**	83.7	6.1%
26.3 Millcreek (East)	75.0	24,685	12.5%	6.0*	82.0	5.3%
27.1 Holladay V2	83.3	25,418	13.7%	2.5*	80.7	14.7%
28 Cottonwood	80.3	43,027	13.2%	7.6	82.2	13.3%
29.1 Kearns V2	124.9	40,856	43.1%	9.5	74.3	20.1%

UTAH DEPARTMENT OF HEALTH

Local SDoH Pilot Projects in “Very High” HII Areas

Glendale

Systems Mapping Project



Delta/Fillmore

- Community Night Out Event Surveys
- Info on Assets, Challenges, and Suggestions for Improving the Community

Ogden

OgdenCAN + Weber Morgan HD

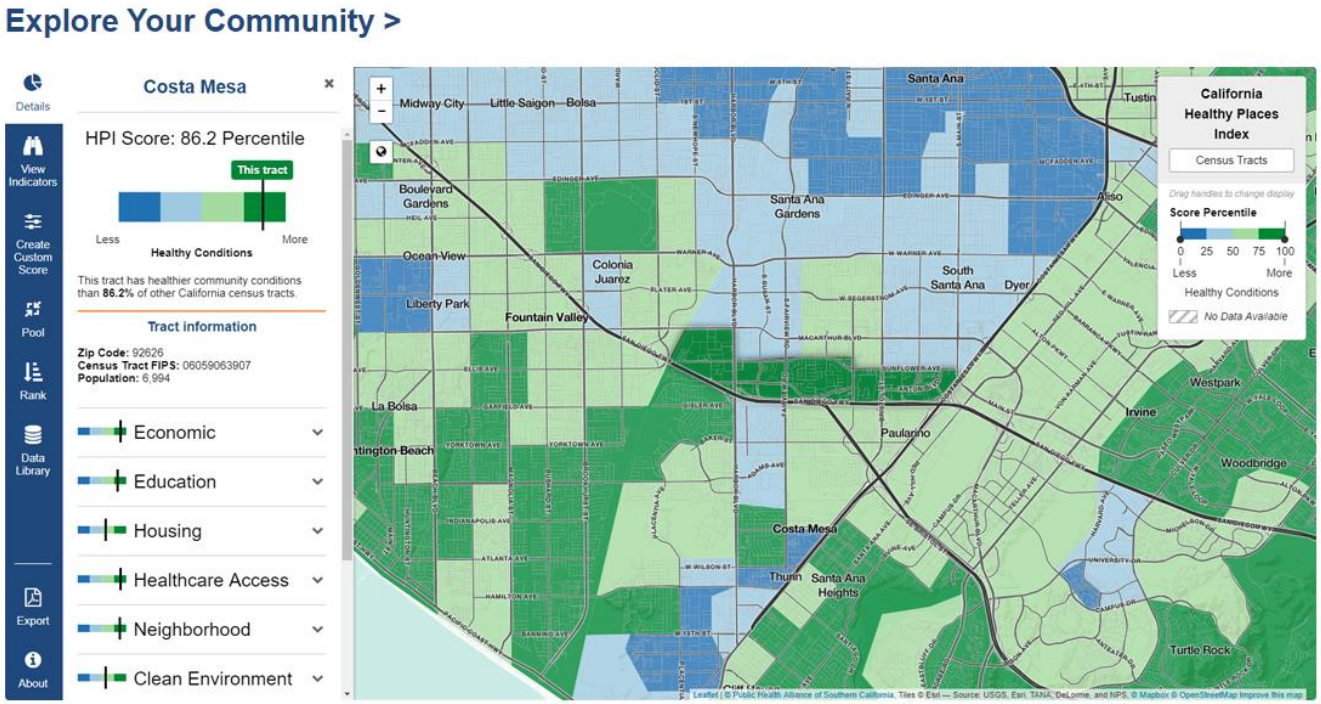
- Health
- Education
- Housing

CASPER Assessment

Cedar City

TBD

Utah Social Determinants of Community Health Index



The California Healthy Places Index: https://healthyplacesindex.org/

Utah Health Information Network

Matt Hoffman, MD, MS, Chief Medical Informatics Officer

Discussion